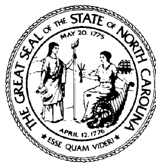
MENTAL HEALTH INITIAL LICENSURE APPLICATION PACKET

Form# DHHS/DHSR/MHL5001
Revised 9/16/2011

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure and Certification Section



North Carolina Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure and Certification
2718 Mail Service Center • Raleigh, North Carolina 27699-2718
http://www.ncdhhs.gov/dhsr/
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Phone: 919-855-3795
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Memorandum

To: **Mental Health, Developmental Disabilities, and Substance Abuse Facility Licensure Applicants**

From: **Mental Health Licensure and Certification Section**

Enclosed you will find an Initial Licensure Application Packet. Included in this packet are the following:

- Licensure Application Process
- Frequently Asked Questions
- Initial Licensure Application
- Photographs sheet
- MH Licensure Policies and Procedures Worksheets

Please read the enclosed information carefully. This information will help you with the following questions:

1. Do the services I want to provide require a license under the mental health/developmental disability/substance abuse (MH/DD/SAS) rules?
2. What service category is the best fit for the service I want to offer?
3. How much are the required fees for a license?

The following publications from the Division of MH/DD/SAS are essential in formulating the REQUIRED Operations and Management Policies, Guidelines and Procedures:

- Rules for Mental Health, Developmental Disabilities and Substance Abuse Services, Title 10A NCAC Chapter 27, Subchapter G (APSM 30-1), cost $5.75;
- Client Rights in Community Mental Health, Developmental Disabilities and Substance Abuse Services, Title 10A NCAC Chapter 27, Subchapters C, D ,E, and F (APSM 95-2), cost $3.00;
- Confidentiality (APSM 45-1) cost $1.50.
- Records Management & Documentation Manuel (APSM 45-2) download only

All publications above may be downloaded free of charge from the internet at www.ncdhhs.gov/mhddsas/statspublications/manualsforms

You may order these publications from the Division of MH/DD/SAS Communications & Training Section for a fee: Phone: (919) 715-2780, e-mail: contactdmh@ncmail.net, mailing address: 3022 Mail Service Center, Raleigh NC 27699-3022. Walk-in address is 325 N. Salisbury St. Suite 1168, Raleigh, NC. Payment accepted by check or money order. Cash or credit card payments are not accepted.

LICENSE APPLICATION PROCESS

License Application Procedure

In order to apply for a license from the Division of Health Service Regulation to operate a mental health facility as required under General Statute 122C, you must do the following:

1. Complete the application

   (a) 24-hour Residential Programs:
   - Take the completed application (pages 12-19)) to your local zoning office and obtain zoning approval. Attach the zoning approval letter to the application.
   - Take the completed application (pages 12-19) to your catchment area Local Management Entity office and obtain a Letter of Support as per Session Law 2005-276. Attach LME support letter to the application. Letter of Support is not required for services that have a Certificate of Need (CON) from DHSR, which currently includes service category .3400 and ICF/MR facilities
   - Submit items required by DHSR Construction Section listed in **Requirements for 24-hour Residential Programs** box below.
   - Include initial licensure fee upon submitting all items.

   (b) Day Programs:
   - Take the completed application (pages 12-19) to your local zoning office and obtain zoning approval. Attach the zoning approval letter to the application.
   - Submit all items listed in **Requirements for Day Programs** box below, including approved Fire Marshal, Sanitation and Building Officials' inspection reports as required.
   - Include initial licensure fee upon submitting all items.
2. Write a letter briefly describing the services to be offered by the facility.
3. Develop written policies and procedures for your services/program, but do not submit them with the application, as they will be reviewed at a later date.
4. Send application with required information to: Division of Health Service Regulation
MH Licensure & Certification Section
2718 MSC
Raleigh, NC 27699-2718
7. Make check payable to: **NC Division of Health Service Regulation**

Note: Before construction of a *new* facility, you must submit blueprints and receive approval from the DHSR Construction Section. For information contact DHSR Construction at #919-855-3893.

Requirements for 24-hour Residential Programs—Existing Structures

Submit the following:

1. A floor plan that specifies the following:
   a. All levels including basements and upstairs.
   b. Identification of the use of all rooms/spaces.
   c. Dimensions of all bedrooms, excluding any toilets, bathing areas and closets. Clarify double or single occupancy.
   d. Location of all doors and the dimensions of all exterior doors.
   e. Location of all windows including the dimensions of bedroom windows and sill height of bedroom windows above the finished floor.
   f. Location of all smoke detectors noting whether they are battery operated, wired into the house current with battery backup, and if they are interconnected.
2. Exterior photos of each side of the building.
3. Interior photos of the kitchen, living areas, bedrooms, and any other rooms.
4. Directions from Raleigh or a map from the nearest major highway, street or intersection clearly showing the location of the facility.
5. **Local Zoning Department approval** for the proposed use**.**

Requirements for Day Programs

Submit the following:

1. A floor plan of the entire building or floor within the building of the space to be licensed that specifies the following:
   a. Identification and dimensions of rooms to be licensed.
   b. Exits from the licensed space and building.
   c. Toilet areas and other required support spaces.
2. Exterior photos of each side of the building.
3. Interior photos of the proposed licensed space.
4. Directions from Raleigh or a map from the nearest major highway, street or intersection clearly showing the location of the facility.
5. **Local Zoning Department approval** or verification the facility is classified under building/planning for intended use.
6. Current **local Fire Marshal's Inspection Report for the building**.
7. Current **local Sanitation Inspection report** if serving any food.
8. **New Construction/Renovation:** the **local Building Officials approval.**
9. **Existing Structure**: If this is an existing Business Occupancy building (as classified under the North Carolina state building code) and it is only a change of tenant use (for a program that is classified as a 'Business Occupancy use') approval from the local Building Official may **not** be required. Contact your local Building Official and provide them with a copy of your application to verify if your program is classified as a Business Occupancy and if they need to provide any type of documentation. NOTE: Any Day Treatment Program for Children and Adolescents cannot be located in a building classified as a Business Occupancy. These programs are required to meet either Group E-Educational Occupancy or Group I-4 - Child Daycare Occupancy under the NCSBC.

License Application Checklist

Incomplete applications will be returned to sender, without processing, accompanied by a letter explaining the incorrect or missing information. Please complete the appropriate checklist prior to submitting your license application.

24-Hour Residential Checklist		
	Item	**Completed**
1.	Cover Letter	
2.	Completed Initial Licensure Application (form DHSR 5001),	
3.	LME Support Letter (not required for Service category .3400 nor ICF/MR)	
4.	Fee	
5.	Floor Plan with dimensions (specify residential)	
6..	Pictures (Interior & Exterior)	
7.	Zoning Approval (original) ***Required for application to move forward***	
8.	Directions to Facility	

Day Program Checklist		
	Item	**Completed**
1.	Cover Letter	
2.	Completed Initial Licensure Application (form DHSR 5001),	
3.	Floor Plan with dimensions (specify residential)	
4.	Fee	
5.	Pictures (Interior & Exterior)	
6.	Zoning Approval (original) ***Required for application to move forward***	
7.	Directions to Facility	
8.	Fire Inspection (clear copy or original)	
9.	Sanitation Inspection (clear copy or original) if serving food	
10.	Building Inspection (original) if applicable for new construction or renovation of building	

License Fees: Annual & Construction

All licensed facilities, residential and non-residential are required to pay an annual licensure fee. NC General Statute 122C-23:

- Prohibits the issuance of the license until the license fee is paid.
- Mandates that licenses must be renewed annually and will expire at the end of the calendar year.

Please submit Licensure fee with the application. Do not submit the Construction fee. Our Construction section will bill you for the applicable fee prior to conducting their site visit.

Initial Licensure Fee NC General Statute 131E-272: Following is a list of types of facilities with required fee, including the base fee and the per bed fee.

Type of Facility	Number of Beds	Base Fee	Per Bed Fee
Non-residential Facilities	0	$265.00	N/A
Residential Facilities (Non-ICF/MR)	6 beds or less	$350.00	$0
Residential Facilities (Non-ICF/MR)	7 beds or more	$525.00	$19.00
ICF/MR* Facilities	6 beds or less	$900.00	$0
ICF/MR* Facilities	7 beds or more	$850.00	$19.00

*ICF/MR: Intermediate Care Facility for the Mentally Retarded, a specialized Medicaid facility requiring a Certificate of Need from the DHSR Certificate of Need Section.

Construction Fees: In addition to the license fee, the DHSR Construction Section has a one-time, per project fee to review the physical plant requirements. You will receive an invoice from the Construction Section for the appropriate fee. Following is a list of fees:

Type of Facility	Number of Beds	Project Fee
Non-ICF/MR Facilities	1-3	$125.00
Non-ICF/MR Facilities	4-6	$225.00
Non-ICF/MR Facilities	7-9	$275.00
ICF/MR Group Homes	1-6	$350.00
Other Residential	10 or more	$275.00 + $.15/sq.ft. project space

Contact Information

Please contact the Construction Section at (919) 855-3893 or the Mental Health Licensure and Certification Section at (919) 855-3795 with any questions. Direct all questions concerning the licensing process to the Mental Health Licensure and Certification Section Raleigh office at (919) 855-3795 or Asheville office at (828) 665-8705.
For further information, the DHSR web site address is: www.ncdhhs.gov/dhsr/

Licensing Process

Provider Action	DHSR Action
Submit: ▪ Completed application ▪ Zoning approval ▪ LME support letter (residential only) ▪ Applicable inspections ▪ Licensure fee	**MH Licensure & Certification Section:** ▪ Reviews application for completeness and process application ▪ Return incomplete application packet to sender. ▪ Forwards completed application to DHSR Construction Section if residential or warranted.
▪ Pay construction fee after receiving Construction invoice. ▪ Meet with DHSR Construction Inspector on site for physical plant review.	**DHSR Construction:** ▪ Invoices applicant for project fee. ▪ Places applicant on site-visit list after receipt of project fee. ▪ Reviews blue prints/floor plans, makes site visit, determines compliance, ▪ If in compliance, recommends building for licensure to MH Licensure and Certification Section. ▪ If deficiencies found, DHSR Surveyor may need to conduct another on-site visit to verify compliance.
▪ Meet with MH Licensure & Certification Section Surveyor for policy and personnel review.	**MH Licensure & Certification Section** ▪ Reviews license application packet and contacts provider to schedule a review. ▪ Review will include: 1. Policies and Procedures as set forth in 10A NCAC 27G (APSM 30-1) 2. Client Rights Policies and Procedures as set forth in 10A NCAC 27C, D, E, F (APSM 95-2) 3. Personnel Requirements as set forth in 10A NCAC 27G .0202 4. Medication Administration and Client Rights Training 5. Program Specific Training specified in rule (i.e. confidentiality, symptoms of substance abuse, development of individual treatment plans, etc.). ▪ Recommends license approval when in compliance. ▪ Generates and mails license to licensee at mailing address on application.

FREQUENTLY ASKED QUESTIONS

Below are a number of questions routinely asked regarding licensure and the provision of mental health services followed by a response in *italics*.

1. **Where do my client referrals come from?**
There are a variety of referral sources in the community (i.e. families, hospitals, periodic, providers, group homes, etc.) As a new provider, you must market your agency to the community by having open houses, sending fliers/brochures, etc. to the various community partners. For state funded services, the LME is the source of referrals and the provider must have a State Funded contract with the LME to receive this type of referral.

2. **Do I have to have a Qualified Professional or "Q"?**
Twenty four-hour, day treatment, and outpatient treatment facilities are required to have a Qualified Professional assist in the development of client treatment/habilitation plans to ensure treatment outcomes. The type of service you are licensed to provide and the type of clients you serve will dictate the type of Qualified Professional you must have. 10A NCAC 27G Section .0100 includes definitions, education and experience requirements of qualified professionals.

3. **Do I have to pay the Qualified Professional or "Q"?**
There is no licensure rule requiring a mental health provider to pay for the services of a Qualified Professional, however "Q"s are professionals who generally charge a fee for their services. Payment for the services of a Qualified Professional is governed by a variety of factors including hours worked, the specific services provided, and years of experience.

4. **Do I have to be licensed before I can serve clients?**
YES. Serving most clients without first obtaining a license is a violation of the law. Specifically, North Carolina General Statute 122C-28 states: "Operating a licensable facility without a license is a Class 3 misdemeanor and is punishable only by a fine not to exceed fifty dollars ($50.00), for the first offense and a fine, not to exceed five hundred dollars ($500.00), for each subsequent offense. Each day's operation of a licensable facility without a license is a separate offense."

5. **Do all staff need training to work in the facility or to provide services?**
YES. All staff must be trained <u>and</u> competent to provide services to mental health clients. Failing to have trained and competent staff may result in poor care for clients, may place clients' health and safety at risk, may place the health and safety of the staff at risk, and may increase provider liability.

6. **How do I get people trained? Where can I send them?**
Staff training should be provided by a person who is competent in the area in which staff need training. Training in medication administration, for example, must be conducted by a licensed registered nurse, pharmacist, or other legally qualified person as per 10A NCAC 27G .0209(c)(3). Training in client rights, including restrictive interventions must be conducted by a person trained in these areas and is qualified to train others. Training resource information is available on the Division of MH/DD/SAS web site: http://www.dhhs.state.nc.us/mhddsas/
We also recommend your Qualified Professional as a resource for assisting, developing or performing some of the required training. Your LME may also be a resource for training resources.

7. **Do I need my staff in place for the initial licensure survey?**
YES. DHSR will not issue a license to a provider who does not have staff in place.

8. **How much money will I get for keeping clients?**
Reimbursement of mental health services varies according to the population served (i.e. adults, minors, etc.), the disability for which services are provided (i.e. mental illness, developmental disabilities or substance abuse problems), and the funding source used for reimbursement (i.e. Medicaid, Special

Assistance, etc.). DHSR does not handle billing, funding, or client placement. Reimbursement information can be found on the Division of MH/DD/SAS web site as noted above.

9. Do you know of any consultants who can write policies?
DHSR does not maintain information on consultants who write policies and procedures for mental health providers. To recommend consultants would be a conflict of interest for DHSR as a regulatory agency.

10. What are the fee's charged to open a facility?
Please see the fee portion of the application packet for this information.

11. Can facilities be licensed in mobile/manufactured home?
YES, but there are restrictions. These restrictions include: (1) .5600 and .5100 are the only two licensure categories that allow mobile/manufactured homes, and (2) the maximum number of clients is three. In addition, a waiver is required for this setting (contact Construction Section).

12. How do I clarify to the local authorities the type of facility I am proposing to operate?
Take the completed Service Categories section in the Licensure Application to your Zoning, Building and/or Fire officials. Providers of Day, Outpatient and Residential need zoning approval.
24 hour residential services must present completed application to their LME (Local Management Entity/Local Area Mental Health Agency) to request a letter of support.

13. Do I have to upgrade the facility to meet handicap accessibility?
If you provide residential services for handicapped clients, you need to provide proper accommodations. Contact your local building official for information.

14. Can someone from Construction come to look at a facility prior to my renting or leasing it?
NO. You need to review the Physical Plant requirements in 10NCAC 27G--Section .0300 to verify the facility meets the construction, space and other physical plant requirements for the clients to be served. You may, however, contact the DHSR Construction Section for specific questions.

15. Can we use a rope ladder for a second escape?
NO. A facility required to provide a second remote exit from any story must be a door with stairs meeting the North Carolina State Building Code.

16. What are the requirements for a Day Facility?
Physical Plant requirements are on page 3 of the application packet. No DHSR-Construction fees are required at this time.

17. How do I get a Letter of Support?
24 hour residential applicants must contact the LME (Local Management Entity) in the catchment area to verify/review if there is a need for the particular twenty-four hour residential service (see 10ANCAC 27G .0406). The LME will issue the letter of support which needs to be enclosed with the initial licensure application or a change application if changing service category..

18. When do I need to renew my license?
All licenses expire at the end of the calendar year. A renewal application will be sent in October to be returned before the end of that year with the annual fee and appropriate inspections.

N.C. Department of Health and Human Services

Division of Health Service Regulation
Mental Health Licensure and Certification Section
2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

INITIAL LICENSURE APPLICATION FOR MH/DD/SAS FACILITIES

Office use only: ***License Number:*** **MHL-__________-__________** ***FID#*** ________________________

1. **FACILITY NAME:** ____
   - Name which the facility is advertised or presented to the public. This is the name that will be printed on your license. Refer to this facility name in ALL inquiries

2. **FACILITY SITE ADDRESS: (NO P.O. BOXES)**

Street: ____

City ________________Zip Code______________County______________________________

*Facility Telephone Number (________)____________________Fax Number (________)____________________
*must be installed and operable prior to licensing-not allowed to be a cell phone.

3. **FACILITY CORRESPONDENCE MAILING ADDRESS:**

Name: ____

Street: ____

City_____________________Zip Code______________County______________________________

Email Address (to which all correspondence will be sent): ______________________________

4. **NAME OF FACILITY DIRECTOR**:______________________________

5. **NAME OF CONTACT PERSON:** ______________________________

Title: ____

Telephone Number (_____)________________ Cell (___)_____________Fax Number (_____)________

6. **SIGNATURE OF LICENSEE OR PERSON WITH SIGNATORY AUTHORITY:** The undersigned, representing the governing authority, submits information for the above named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

Name: ______________________________Title: ______________________________

Signature: ______________________________Date: ______________________________

ALL APPLICATIONS MUST BE MAILED TO ABOVE ADDRESS AND MUST HAVE AN ORIGINAL SIGNATURE

OFFICIAL USE ONLY: DHSR Form 4080

Licensure Categories: ____
Licensure Recommendation:____
Remarks: ____
DHSR Consultant: ____

7. **MANAGEMENT COMPANY:** If facility is managed by a company ***other than the licensee***, provide the following information about the Management Company:

Name:____

Address:____

Telephone Number (______)_________________Fax Number (______)____________

8. **LOCAL MANAGEMENT ENTITY (LME):** List name(s) of LMEs with which the facility has a contract:

____

____

____

9. **LEGAL IDENTITY OF LICENSEE:**

Full legal name of individual, partnership, corporation or other legal entity, which owns the mental health facility business, is required. Owner/Licensee means any person/business entity (Corp., LLC, etc.) that has legal or equitable title to or a majority interest in the mental health facility. This entity is responsible for financial and contractual obligations of the business and will be recorded as the licensee on the license. ***Please be sure to write the name of the owner exactly the same on all documents.***

(a) Name of Owner (Corp, LLC, etc): ____

Address: ____

City: ____________________________State:___________________Zip Code:______________________

Business Phone #: (______)_______________________Fax (______)______________________

(b) Federal Tax ID number of Owner/Licensee**:** ___________________________________

(c) Legal entity is: _____ For Profit _____ Not for Profit

(d) Legal entity is:

_____ Proprietorship
_____ Corporation
_____ Partnership
_____ Government Unit
_____ Limited Liability Company
_____ Limited Liability Partnership

(e) Name of CEO/President:______________________________Title: ____________________________

Address: ____

City: ____________________________State:___________________Zip Code:______________________

Business Phone #: (___)______________Cell# (____)____________Fax (___)____________________

If the "licensee" is a corporation or partnership list the name of the Executive Officer or General Partner.

(f) Building Owner: If the above entity (partnership, corporation, etc.) ***does not*** own the building from which services are offered, please provide the following information:

Name of Building Owner: ____

Address: ____

City: ____________________________State:___________________Zip Code:______________________

Business Phone #: (_______)__________________________Fax (________)_____________________

Facility Name:____________________MHL #:___________________

10. OWNERS, PARTNERS, AFFILIATES, SHAREHOLDERS (Confidential Information for Official Use Only)

Non-Profit Companies

If no individual holds an interest of 5% or more please sign the statement below, thereby indicating this is a non-profit group.

There are **no owners, partners, affiliates of shareholders who hold an interest of 5% or more** of the licensee applying for or renewing a license:

___________________________________ _______________________________ ________________
Signature Title Date

For-Profit Individuals or Companies

Complete the information below on **all** individuals who are owners, partners, or shareholders holding an interest of 5% or more of the licensee listed on page 2. Attach additional pages if necessary*. We ask that you voluntarily provide your social security number with the understanding that it will be used only as an identification number for internal record keeping and data processing*
If you are the only owner, complete the information below, listing the percentage interest as 100%.

Owner or Shareholder Name: ______________________________Social Security Number: __________
Address: ____
City: ______________________________State:___________________Zip Code:___________________
Phone # of Shareholder: (________)_____________________Fax (________)__________________
Percentage interest in this facility: ______________Title: ______________________________________

Owner or Shareholder Name: ______________________________Social Security Number: __________
Address: ____
City: ______________________________State:___________________Zip Code:___________________
Phone # of Shareholder: (________)_____________________Fax (________)__________________
Percentage interest in this facility: ______________Title: ______________________________________

Owner or Shareholder Name: ______________________________Social Security Number: __________
Address: ____
City: ______________________________State:___________________Zip Code:___________________
Phone # of Shareholder: (________)_____________________Fax (________)__________________
Percentage interest in this facility: ______________Title: ______________________________________

10. EXTENSIONS IN OWNERSHIP:

North Carolina General Statute 122C-23 also requires information about "affiliates" of the applicant entity.

(a) Is the facility controlled by an organization that operates any other licensed mental health facility?
Yes _____ No _____

(b) Does the applicant control any other licensed mental health facilities? Yes _____ No _____

(c) Does the applicant control other organizations that control Mental Health facilities? Yes___ NO ___

(d) If the answer to (a) or (c) above is "Yes" list the name of the other organization(s)

Organization Name: ______________________________Federal Tax ID Number: __________________
Address: ____
City: ____________________________State:__________________Zip Code:_____________________
Organization Phone #: (________)____________________Fax (________)______________________
Senior Officer or CEO:____
Chairman of the Board: ____

Organization Name: ______________________________Federal Tax ID Number: __________________
Address: ____
City: ____________________________State:__________________Zip Code:_____________________
Organization Phone #: (________)____________________Fax (________)______________________
Senior Officer of CEO: ____
Chairman of the Board:____

11. SERVICE CATEGORIES:

Services subject to licensure under G.S. 122C are shown in the table below and are **found in the Rules For Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services**. All applicants must complete the following table for all services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	**Check Service of License**	**Beds Assigned by Age**		
		0-17	**18 & up**	**Total Beds**
.1100 Partial hospitalizations for individuals who are acutely mentally ill.				
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness				
.1300 Residential treatment facilities for children or adolescents—Level II (Max. of 12 clients)				
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances				
.1700 Residential treatment Staff Secure for Children or Adolescents—Level III (Max of 12 clients)				
.1800 Intensive residential treatment for children or adolescents (Level IV)				
.1900 PRTF – Psychiatric Residential Treatment Facility for minors who are emotionally disturbed or who have a mental illness.				

.2100 Specialized community residential centers for individuals with developmental disabilities. (Max. of 30 clients) (CON Required if ICF/MR)				
.2200 Before/after school and summer developmental day services for children with or at risk for developmental delays, developmental disabilities, or atypical development				
.2300 Adult Developmental and vocational programs for individuals with developmental disabilities				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	**Check Service of License**	**Beds Assigned by Age**		
		0-17	**18 & up**	**Total Beds**
.3100 Non-hospital medical detoxification for individuals who are substance abusers				
.3200 Social setting detoxification for substance abuse				
.3300 Outpatient detoxification for substance abuse				
.3400 Residential treatment/rehabilitation for individuals with substance abuse disorders (CON Required)				
.3600 Outpatient narcotic addiction treatment				
.3700 Day treatment facilities for individuals with substance abuse disorders				
.4100 Therapeutic homes for individuals with substance abuse disorders and their children (min. 3 clients)				
.4300 A supervised therapeutic community for individuals with substance abuse disorder				
.4400 Substance Abuse Intensive Outpatient Program				
.4500 Substance Abuse Comprehensive Outpatient Treatment Program				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
.5000 Facility based crisis service for individuals of all disability groups				
.5100 Community respite services for individuals of all disability groups				
.5200 Residential therapeutic (habilitative) camps for children and adolescents of all disability groups				
.5400 Day activity for individuals of all disability groups				
.5500 Sheltered workshops for individuals of all disability groups				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities *Only one of these categories can be checked*	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
. 5600 supervised living for individuals of all disability groups				
5600**A** Group homes for <u>adults</u> whose primary diagnosis is mental illness (Max. of 6 clients)				
5600**B** Group homes for <u>minors</u> whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients) (CON required only if ICF/MR)				
.5600**C** Group homes for <u>adults</u> whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients) (CON required only if ICF/MR)				
.5600**D** Group homes for <u>minors</u> with substance abuse problems				
.5600**E** Half-way houses for <u>adults</u> with substance abuse problems				
.5600F Alternative family living – providing service in own private residence (Max. 3 clients)				

12. DO YOU HAVE A CERTIFICATE OF NEED? Yes ☐ No ☐

Required for the following service categories: .3400, or .2100 & .5600 only for ICF/MR designation

If yes, CON Number ________________Date _________________

13. NUMBER OF CLIENTS FOR WHICH THE FACILITY IS GOING TO BE LICENSED:

Type	Specify Number to be Licensed
Ambulatory*	
Non-Ambulatory, 1-3	
Non-Ambulatory, 4 or more	

***Ambulatory: a person who can evacuate the building without physical or verbal assistance during a fire or other emergency.**

14. NUMBER AND AGE(s) OF PEOPLE OTHER THAN CLIENTS RESIDING WITHIN THE FACILITY:

(applicable only in categories where private residence is allowable: .5600 F & .5100 Private Home Respite)

____

____

Are any of these non-ambulatory? Yes ☐ No ☐

CONSTRUCTION: PHYSICAL PLANT

Please fill in EACH inspection Department information:

Zoning Department Official

Department Name: ______________________________ Official's Name: ________________________

Address: ____

City: ___________________________ State: __________________ Zip Code: ____________________

County: ___________________________________ Phone:(______) ______________________________

Local Building Official

Department Name: ______________________________ Inspector Name*: ________________________

Address: ____

City: ___________________________ State: __________________ Zip Code: ____________________

County: ___________________________________ Phone :(______) _____________________________

Local Fire Marshall

Department Name: ______________________________ Inspector Name*: ________________________

Address: ____

City: ___________________________ State: __________________ Zip Code: ____________________

County: ___________________________________ Phone :(______) _____________________________

Local Sanitation

Department Name: ______________________________ Inspector Name*: ________________________

Address: ____

City: ___________________________ State: __________________ Zip Code: ____________________

County: ___________________________________ Phone :(______) _____________________________

***Provide Inspector's name if Inspection completed and copy attached.**

Building Information: Complete for 24-hour residential facilities only:

Has the building housed a licensed facility previously? Yes ☐ No ☐

If Yes: Type of licensed facility ___________________________________

Previous License # ______________________ Dates of Licensure: From __________ To: __________

Does this building(s) contain facilities licensed for a different use other than the one an initial license is being sought for? Yes ☐ No ☐

If Yes, please clarify type of license ____

Is the building a site constructed home or a manufactured/mobile home? ______________________

(*If it is a manufactured/mobile home – contact the DHSR Construction Section for licensure limitations on this type of structure)

If it is a manufactured/mobile home, was it built after 1976? Yes ☐ No ☐

PHOTOGRAPHS

NAME OF FACILITY: ___________________________

COUNTY: ___________________________________

Please attach photos of your facility, as required, to this sheet and add other blank sheets as needed. **Please label each photograph as to identity of room** within the facility and **also** on the **back of the photo** **identify with the name and address of the facility** (to help identify picture should they get separated) Thank you.

MH Licensure Policies and Procedures Worksheets

The following worksheets are used by our surveyors in the initial application process. They may be helpful to you in assuring that your policy and procedure manual is complete.

Division of Health Service Regulation
Mental Health Licensure and Certification Section
Policy & Procedures: Initial Licensure Survey

Important Note: This form is a tool designed to help the MHL&C initial surveyor while reviewing the agency's policy & procedure manual. The information below is only a snapshot of the actual rules and *is not* a substitute for obtaining the licensure rule book. Providers are welcome to use the form as a tool if desired but it is not a requirement.

Facility Name:		MHL#:		10NCAC 27G Licensure Code(s):	
County:		Date:		Time Begin:		Time End:	
Consultant Name:		Type of survey (initial or change):	

Section 10A NCAC 27G .0200 Operation and Management Rules

10A NCAC 27G .0201: Governing Body Policies

☐ **Delegation of Management Authority**	☐ **Admission Criteria**	☐ **Discharge Criteria**
☐ **Who Will Perform Assessments**	☐ **Assessment Time Frame**	☐ **Persons authorized to document in ct record**
☐ **Transporting Records**	☐ **Safeguarding of Records**	☐ **Accessibility of records to Authorized Persons**
☐ **Assurance of Confidentiality of Records**	☐ **Assessment of Presenting Problem**	☐ **Assessment of Ability to Provide Service(s)**
☐ **Disposition of Ct(s)**	☐ **QA/QI Activities and Composition**	☐ **Written Plan for QA/QI**
☐ **Methods of Monitoring Ct Care**	☐ **Qualified Supervision**	☐ **Intervention Advisory Committee**
☐ **Strategies for Improving Ct Care**	☐ **Staff Credentialing/Privileging**	☐ **Review of Fatalities**
☐ **Standards of Practice**	☐ **Incident Reporting**	☐ **Medication Usage (27G .0209 for detailed list)**
☐ **Voluntary Non-Compensated Ct Work**	☐ **Fee Assessment & Collection**	☐ **Medical Emergency Plan**
☐ **Authorization for Follow Up of Lab Tests**	☐ **Transportation**	☐ **Safety Precautions (Fire/Disaster Plan)**
☐ **Volunteers: Confidentiality Requirements**	☐ **Staff Training & CEU's**	☐ **Ct Grievance Policy**
☐ **Infectious Disease (identify, control, report, investigate)**		

10A NCAC 27G .0203: Competencies of Qualified and Associate Professionals

☐ **Initiation of individualized supervision plan upon hiring each associate professional**

10A NCAC 27G .0204: Competencies and Supervision of Paraprofessionals

☐ **Initiation of individualized supervision plan upon hiring each paraprofessional**

10A NCAC 27G .0209 Medication Requirements

☐ **Meds dispensed only by written MD order**	☐ **Dispensing of meds only by Licensed Person**	☐ **Take home Methadone given to ct by RN only**
☐ **Facilities shall not keep prescription drugs for dispensing without a Pharmacist, except for emergency use. A small supply of samples may be kept and locked by MD**	☐ **Non-Prescribed drug containers not dispensed by a Pharmacist must have original label with expiration dates visible.**	☐ **Prescription meds must be dispensed in tamper resistant packaging**
☐ **Label on prescription meds must include: Ct name; MD name; dispensed date; administration directions; name, strength, quantity & expiration date of drug; name & address of Pharmacy; name of Pharmacist**	☐ **Meds administered by written MD order**	☐ **Meds self administered only on with written MD order**
☐ **Med administration only by trained staff**	☐ **6 month drug review by a Psychiatrist or Pharmacist required if taking Psychotropic meds**	☐ **Findings from drug review recorded in ct record with corrective action plan**
☐ **Staff is responsible for informing MD of review results if medical intervention is indicated**	☐ **Meds prescribed by an area program MD will give written or oral instructions**	☐ **Med education will be enough to allow for ability to make informed consent**
☐ **The area program will have written documentation in ct record that education was given, to whom & in what format**	☐ **Ct request for med changes/checks on MAR**	☐ **Non-controlled meds must be disposed of by flushing or returning to pharmacy**
☐ **Controlled meds must be disposed of by the rules in NC controlled Substance act G.S. 90**	☐ **Documentation of disposal in record with ct name, med name, strength, quantity, disposal date & method, signature of disposer & witness**	☐ **Upon ct discharge, meds shall be disposed of immediately**
☐ **Meds must be locked**	☐ **Refrigerated meds must be in separate locked container**	☐ **Meds must be stored separately for each ct**
☐ **Meds must be stored separately for internal & external use**	☐ **Meds must be stored in a secure place for ct approved to self-administer**	☐ **A facility must be registered under G.S. 90, article 5 if controlled substances are on premises**
☐ **MAR must be kept current**	☐ **MAR must include: ct name, name, strength & quantity of drug; instructions for administration; date & time of administration; initials of person administering med**	☐ **Med errors are to be recorded in MAR**

☐ **Med refusal or adverse reactions are to be recorded**	☐ **Severe reactions to be immediately reported to MD or Pharmacist**

Notes:

Section 10A NCAC 27D Client Rights in Community Mental Health, Developmental Disabilities & Substance Abuse Services

10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions

☐ **Alleged/suspected abuse/neglect/exploitation reported to are DSS**	☐ **Safeguards are used when meds present an increased risk to ct (i.e. neuroleptics)**	☐ **Identify prohibited restrictive interventions (RI)**
☐ **24hr facility: Identify circumstances when staff cannot restrict the rights of cts**	☐ **Identify allowed RI**	☐ **Staff responsible for informing ct**

☐ **Due process procedure for ct refusing RI**	☐ **Identify staff responsible for giving written permission for 24hr RI**	☐ **Identify staff responsible for review of RI**
☐ **Process of appeal for disagreement over planned use of RI**	☐ **Ct's physical and psychological well-being to include: review of cts health history or comprehensive health assessment; continuous assessment & monitoring of the ct's physical/ psychological well being throughout the duration of RI; continuous monitoring of the ct's physical/psychological well being by a staff training in CPR; and continuous monitoring of the ct's well being for a minimum of 30 minutes by a staff trained in CPR**	☐ **Following the use of RI, the staff shall conduct a debriefing and planning with the ct and legally responsible person. This process should be conducted based on the cognitive functioning of the ct.**

10A NCAC 27D .0102 Suspensions and Expulsion Policy

☐ No ct shall be threatened w/unwarranted suspension or expulsion	☐ **Policy & criteria for suspension**	☐ Time and conditions for resuming services
☐ Documentation of efforts to make alternative services available	☐ Discharge Plan, if any	

10A NCAC 27D .0103 Search and Seizure Policy

☐ Ct should have privacy	☐ **Policy on search/seizure of ct's possessions (including circumstances)**	☐ Documentation of search/seizure including: Scope, search, reason, procedures followed, account of disposition of seized property

10A NCAC 27D .0104 Periodic Internal Review

☐ Facility shall conduct a review at least every 3 years to check for compliance with applicable laws	☐ The governing body will keep the last 3 written reports of the findings of the reviews

10A NCAC 27D .0201 Informing Clients

☐ Written client rights given to ct or guardian	☐ Each ct must be informed of right to contact Governor's Advocacy Council	☐ Documentation in record that rights were explained
☐ Within 72 hours or three visits, ct will be informed of rules and violation penalties; disclosure rules for confidential info; procedure for obtaining a copy of treatment plan; grievance procedure (including contact person); suspension/expulsion and search and seizure		

☐ In facilities using RI: within 72 hours or 3 visits, ct will be informed of the purpose, goal & reinforcement structure of a behavior management system; potential restrictions; notification provisions regarding use; notice that the legally responsible person after use of a RI; a competent adult may designate an individual to receive information after RI and notification provisions regarding restriction of rights

10A NCAC 27D .0202 Informing Staff

☐ **Written policy on informing staff of ct rights**	☐ Documentation of receipt of information by each staff

10A NCAC 27D .0301 Social Integration

☐ Each ct will be encouraged to participate in activities	☐ Cts will not be prohibited from activities unless restricted in writing and in record

10A NCAC 27D .0302 Client Self Governance

☐ **Written policy allows ct input into facility governance & development of ct self governance groups**

10A NCAC 27D .0303 Informed Consent

☐ Ct will be informed about the alleged benefits, potential risks and alternative treatments	☐ Ct will be informed about the length of time the consent is valid and procedure to withdraw consent	☐ Consent for use of RI valid for 6 months
☐ Written consent needed for planned interventions	☐ Written consent needed for antabuse & Depo-Provera, when used for non FDA approved uses	☐ Cts have a right to refuse treatment, shall not be threatened with termination
☐ Documentation of informed consent in ct record		

10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation

☐ Staff will protect clients from harm, abuse, neglect and exploitation	☐ Staff will not inflict harm, abuse, neglect or exploit ct	☐ Goods/services will not be sold to or purchased from ct except through established policy
☐ Staff will only use the degree of force necessary to repel or secure a violent/aggressive ct and which is permitted by the policies. The degree of force necessary depends on the characteristics of the ct and the degree of aggressiveness. Use of interventions in agreement with 10A NCAC 27D		☐ Any violation of this rule by staff is grounds for dismissal

Notes:

Section 10A NCAC 27E Treatment of Habilitation Rights

10A NCAC 27E .0100 Protection Regarding Intervention Procedures

☐ If the Facility uses Seclusion, Restraints and Isolation Time Out this section must be checked in the rulebook and must be reflected in the facility's policy and procedure manual.

10A NCAC 27E .0101 Least Restrictive Alternative

☐ Facilities shall provide services using the least restrictive, most appropriate and effective positive treatment policy	☐ The use of RI to reduce a behavior will be used with positive treatment or habilitation methods	☐ Treatment methods shall include: deliberative teaching & reinforcement of behaviors which are non-injurious; improvement of conditions associated with non-injurious behaviors (i.e. enriched social and educational environment); alteration or elimination of environments conditions correlated with self injury

10A NCAC 27E .0102 Prohibited Procedures

☐ The following procedures are prohibited: corporal punishment; painful body contact; substances which create painful bodily reactions; electric shock; insulin shock; unpleasant tasting foodstuffs; application of noxious substances (noise, bad smells, splashing with water); physically painful procedures to reduce behavior	☐ The governing body may determine to prohibit use of any interventions deemed unacceptable

10A NCAC 27E .0103 General Policies Regarding Intervention Procedures

☐ The following procedures can only be used when clinically/medically indicated as a method of treatment: planned non-attention to specific undesirable behaviors when they are health threatening; contingent deprivation of any basic necessity or professionally acceptable behavior modification procedures not prohibited by rules .0102 or .0104
☐ The determination that a procedure is clinically/medically indicated and the authorization for use of such treatment for a specific ct can only be made by a physician or a licensed PHD who has been formally trained and privileged in the use of a procedure.

10A NCAC 27E .0104 Seclusion, Restraint and Isolation Time Out

☐ Use of RI shall be limited to emergency situations (to terminate dangerous behavior) or as a planned measure of therapeutic treatment	☐ RI will not be used as retaliation or convenience of staff & will not cause harm
☐ **Written policy delineates use of RI**	☐ **Written policy when RI is used must be written and approved by the Commission and must follow rules 27E .0104(e)(1)(A-D) or the facility must have provisions included in the next box**
☐ (e)(2) Review of ct's health history or ct's comprehensive health assessment conducted upon admission to the facility. The assessment shall include pre-existing medical conditions or any disabilities and limitations that would pout the ct at risk during the RI; continuous assessments and monitoring of the ct's physical and psychological well being throughout the duration of the RI by a staff present and trained in RI; continuous monitoring of the ct's physical and psychological well being by a staff trained in CPR during the use of the restraint and continued monitoring of the ct's physical and psychological well being by a staff trained in CPR for a minimum of 30 minutes to the termination of RI	
☐ If the facility complies with (3) (2) then the following provisions apply: and room used for seclusion will comply with 8(A-I).	☐ When a ct is in seclusion or physical restraint they must be observed ≤ 15 minutes; ct will be allowed meals, bathing and toilet use; both of which must be recorded in the ct record
☐ When RI is used documentation in the ct record will include: notation of the ct's physical and psychological well being, notatation of the frequency, intensity & duration of behavior leading to the RI and circumstances leading to the behavior; rationale for using RI which addresses the inadequacy of less restrictive techniques; description of intervention and date time & duration of use; description of accompanying positive methods of intervention; a description of the debriefing and planning with the ct and legal responsible person for the emergency use of seclusion, physical restraint or isolation time out; a description of the debriefing and planning with the ct and the legal responsible person for the planned use of seclusion, physical restraint or isolation time out; a signature & title of the staff who initiated and the staff who further authorized the use of the intervention	

☐ Emergency use of RI will be limited to : staff privileged to use RI based on experience & training; continued use of interventions will be authorized only by staff privileged to use RI; the responsible staff will meet with and conduct an assessment that includes the physical and psychological well being of the ct and write continuation authorization ASAP after the time of initial use of intervention; verbal authorization can be five if responsible staff concurs that it is justified; verbal authorization will not exceed 24 hours; and a written order for seclusion, physical restraint or isolation timeout is limited	
☐ When RI is used as planned intervention the facility policy shall specify consent or approval valid for no more that 6 months based on recent behavioral evidence intervention is positive and continues to be needed	☐ When ct is in isolation time out there will be staff solely to monitor ct, there will be continued visual and verbal interaction which will be documented in the ct record

- ☐ RI will be discontinued ASAP or within 30 minutes of behavior control, new authorization must be obtained for RI over 30 minuets to four hours for adult cts; two hour for children and adolescents ages 9 – 17; one hour for cts under age 9. The original order shall be renewed with these limits or up to a total of 24 hours.
- ☐ Written approval required for RI exceeding 24 hours
- ☐ Standing orders or PRN orders shall not be used to authorize the use of RI
- ☐ When ct is in physical restraint staff will remain with the ct continuously
- ☐ Documentation of RI must be in ct record. When RI issued notification to the treatment team & designee of the governing body must occur ASAP or within 72 hours
- ☐ Review and report of RI must be conducted regularly; investigations of unusual or unwarranted patterns of utilization
- ☐ Documentation shall be maintained on a log including: Name of ct; name of responsible staff; date, time type, duration, reason for intervention, positive and less restrictive alternative used or considered and why used, debriefing and planning conducted to eliminate or reduce the probability of future use of RI and negative effects of RI on the physical and psychological well being of the ct
- ☐ The facility shall collect and analyze data on the use of seclusion and restraining on the following: the type of procedure used and length of time employed; the alternatives considered or employed; and the effectiveness of the procedure or alternative employed
- ☐ RI can be considered a planned intervention and will be included in the ct's treatment plan when used: ≥ 4X or ≥ 40hrs in 30 consecutive days; in a single episode for ≥24 continuous hrs in an emergency; or as a measure of therapeutic treatment designed to reduce behavior to allow less restrictive treatment
- ☐ When RI is used as a planned intervention the facility policy shall specify consent or approval valid for no more that 6 months based on recent behavioral evidence intervention is positive and continues to be needed
- ☐ Prior to initiation or continued used of planned RI, written consent/approval in ct record – approval of plan by professional and treatment team, consent of ct or legally responsible person, notification of ct advocate, and physician approval
- ☐ Documentation in ct record regarding use of planned intervention shall indicate: description and frequency of debriefing. Debriefing shall be conducted to the level of functioning of the ct; bi-monthly evaluation of the planned intervention by the responsible professional; and review at least monthly by the treatment/habilitation team that approved the planned intervention
- ☐ Ct's are able to request voluntary RI

10A NCAC 27E .0105 Protective Devices

- ☐ When protective devices are used, a written policy will ensure that: the need has been assessed and the device applied by staff trained and privileged to do so; it is the most appropriate treatment; the ct is frequently observed and given opportunity to use the toilet, exercise and is monitored every hour
- ☐ Documentation and interventions will be recorded in ct record
- ☐ Protective devices are to be cleaned regularly
- ☐ Facilities operative by or under contract with an area program will be subject to review by the ct rights committee
- ☐ Use of devices will comply with 27E .0104

10A NCAC 27E .0106 Intervention Advisory Committees (only if RI are used)

☐ An Intervention Advisory Committee will be established to provide additional safeguards in a facility using RI	☐ The Intervention Advisory Committee should have at least one member who has been a member of direct services or a close relative of a consumer and: for an area program facility the Committee will be the ct rights committee; in a facility not operated by an area program, the Committee will be the Human Rights Committee; or a facility will have a committee will have 3 citizens who are not employees of members of the governing body	☐ Intervention Advisory Committees shall have a member or regular independent consultant who is a professional with training and expertise in the use of the type of interventions who is not directly involved with the treatment of the ct

☐ The Intervention Advisory Committee will have a policy that governs the operations and states that ct information will only be given to committee members when necessary to perform duties	☐ Intervention Advisory Committee will receive specific training and orientation, be provided with copies of related statutes and riles, maintain minutes of each meeting, and make an annual written report to the governing body on activities of the committee

10A NCAC 27E .0201 Safeguards Regarding Medications

☐ Use of experimental drugs is research and will be governed by GS 122c-57(f)	☐ Use of other drugs as treatment measure shall be governed by GS 122c-57, GS 90 Articles 1, 4A and 9A

Notes:

Division of Health Service Regulation
Mental Health Licensure and Certification Section
Policy & Procedures: Initial Licensure Survey

Section 10A NCAC 27F Specific Rules for 24-Hour Facilities

10A NCAC 27F .0101 Scope

☐ Article 3, Chapter 122C of the General Statues provides specific rights for each ct who receives a mental health, developmental disability or substance abuse service. This subchapter delineates the rules regarding those rights for cts in a 24-hour facility

10A NCAC 27F .0102 Living Environment

☐ Efforts to make a quite atmosphere for uninterrupted sleep, privacy areas	☐ Ct may suitably decorate room, when appropriate

10A NCAC 27F .0103 Health, Hygiene and Grooming

☐ Ct will have the right to dignity, privacy and humane care in healthy hygiene and grooming	☐ Cts will have access to shower/tub daily or more often as needed; access to a barber or beautician, access to linens and towels and other toiletries
☐ Adequate toilets, lavatory and bath facilities equipped for use by a ct with a mobility impairment will be available	☐ Ct bathtubs, showers and toilets will be private

10A NCAC 27F .0104 Storage and Protection of Clothing and Possessions

☐ Staff will make every effort to protect ct personal clothing and possessions from loss or damage

10A NCAC 27F .0105 Client's Personal Funds

☐ Each ct will be encouraged to maintain funds in a personal account	☐ Funds managed by staff will: assure ct right to deposit and withdraw money; regulate the receipt and distribution, and deposits of funds; provide adequate financial records on all transactions; assure ct funds are kept separate; allow deduction from accounts for payment of treatment/habilitation services when authorized; issue receipts for deposits and withdrawals provide ct quarterly statements	☐ Authorization by ct required before a deduction can be made from an account for any amount owed for damages done by the ct to the facility, to an employee of the facility, a visitor or another ct.